

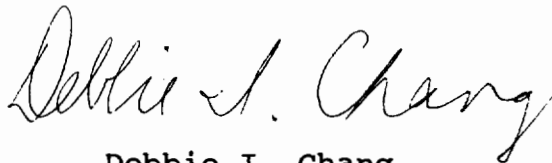
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HCFA LEGISLATIVE SUMMARY

November 30, 1994

SOCIAL SECURITY ACT AMENDMENTS OF 1994
(P.L. 103-432)

On October 31, 1994, the President signed into law H.R. 5252, the Social Security Act Amendments of 1994 (P.L. 103-432). The law makes numerous miscellaneous and technical corrections to various titles of the Social Security Act. This summary describes only those changes that pertain to the Medicare program and (indirectly) Medicaid eligibility requirements.



Debbie I. Chang
Director

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TITLE I -- MEDICARE

SUBTITLE A -- PROVISIONS RELATING TO PART A

Section 101.	Provisions Relating to Adjustments to Standardized Amounts for Wages and Wage-Related Costs	1
Section 102.	Essential Access Community Hospital (EACH) Amendments	1
Section 103.	Provisions Relating to Rural Health Transition Grant Program	2
Section 104.	Psychology Services in Hospitals	2
Section 105.	Medicare-Dependent, Small Rural Hospitals and Sole Community Hospitals	2
Section 106.	Skilled Nursing Facilities	2
o	Construction of Wage Index	2
o	Clarification of Repeal of Utilization Review Requirements	2
o	Conforming Amendments to Nursing Home Reform	3
Section 107.	Notification of Availability of Hospice Benefit	3
Section 108.	Clarifying Expertise of Individuals to Serve on the Prospective Payment Assessment Commission	3
Section 109.	Authority for Budget Neutral Adjustments for Changes in Payment Amounts for Transfer Cases	3
Section 110.	Clarification of DRG Payment Window Expansion; Miscellaneous and Technical Corrections	3

SUBTITLE B -- PROVISIONS RELATING TO PART B

Part I -- Physicians' Services

Section 121.	Development and Implementation of Resource- Based Methodology for Practice Expenses	4
Section 122.	Geographic Cost of Practice Index Refinements	4
Section 123.	Extra-Billing Limits	4
o	Enforcement of Limits	4
o	Clarification of Mandatory Assignment Rules for Certain Practitioners	4
o	Information on Extra-Billing Limits	4

o	Report on Charges in Excess of Limiting Charge . . .	5
o	Miscellaneous and Technical Amendments	5
Section 124.	Relative Values for Pediatric Services	5
Section 125.	Administration of Claims Relating to Physicians' Services	5
o	Limitation on Carrier User Fees	5
o	Clarification of Permissible Substitute Billing Arrangements	5
Section 126.	Miscellaneous and Technical Corrections . . .	6
o	Overvalued Procedures	6
o	Radiology Services	6
o	Anesthesia Services	6
o	Assistants at Surgery	6
o	Technical Components of Diagnostic Services	6
o	Statewide Fee Schedules	6
o	Other Miscellaneous and Technical Amendments	7
o	Other Corrections	7

Part II -- Durable Medical Equipment

Section 131.	Certification of Suppliers	7
o	Requirements	7
o	Use of Covered Items by Disabled Beneficiaries . . .	8
o	Criteria for Treatment of Items as Prosthetic Devices or Orthotics and Prosthetics	8
Section 132.	Restrictions on Certain Marketing and Sales Activities	8
Section 133.	Beneficiary Liability for Noncovered Services	8
o	Unassigned Claims	8
o	Assigned Claims	9
Section 134.	Adjustments for Inherent Reasonableness . . .	9
Section 135.	Miscellaneous and Technical Corrections . . .	9
o	Updates to Payment Amounts	9
o	Advance Determinations of Coverage	9
o	Study of Variations in DME Supplier Costs	10
o	Other Miscellaneous and Technical Corrections . . .	10

Part III -- Other Items and Services

Section 141.	Ambulatory Surgical Center Services	10
o	Payment Amounts for Services Furnished in Ambulatory Surgical Centers	10
o	Adjustments to Payment Amounts for New Technology Intraocular Lenses	10
o	Other Technical Corrections	11

Section 142.	Study of Medicare Coverage of Patient Care Costs Associated with Clinical Trials of New Cancer Therapies	11
Section 143.	Study of Annual Cap on Amount of Medicare Payment for Outpatient Physical Therapy and Occupational Therapy Services	11
Section 144.	Payment of Part B Premium Late Enrollment Penalties by States	12
Section 145.	Application of Mammography Certification Requirements	12
Section 146.	Coverage of Services of Speech-Language Pathologists and Audiologists	12
Section 147.	Miscellaneous and Technical Amendments	12
o	Immediate Enrollment in Part B by Individuals Covered by an Employment-Based Plan	12
o	Other Technical Amendments	12

SUBTITLE C -- PROVISIONS RELATING TO PARTS A AND B

Section 151.	Medicare Secondary Payer Reforms	13
o	Improving Identification of Medicare Secondary Payer Situations	13
o	Improvements in Recovery of Payments from Primary Payers	13
o	Deadline for Reimbursement by Primary Plans	13
o	Miscellaneous and Technical Corrections	13
Section 152.	Physician Ownership and Referral	14
o	Reporting Requirements	14
o	Designated Health Services List	14
o	Revision of Effective Date Exception	14
Section 153.	Definition of FMGEMS Examination for Payment of Direct Graduate Medical Education	15
Section 154.	Qualified Medicare Beneficiary Outreach	15
Section 155.	Hospital Agreements with Organ Procurement Organizations	16
Section 156.	Peer Review Organizations	16
o	Repeal of PRO Precertification Requirement for Certain Surgical Procedures	16
o	PRO Notification of State Licensing and Disciplinary Boards	16

Section 157.	Health Maintenance Organizations	17
o	Revisions in the Payment Methodology for Risk Contracts	17
o	Miscellaneous and Technical Corrections	17
Section 158.	Home Health Agencies	17
o	Use of Most Current Data in Determining Wage Index .	17
o	Clarification of Extension of Waiver of Liability .	18
Section 159.	Permanent Extension of Authority to Contract with Fiscal Intermediaries and Carriers on Other Than a Cost Basis	18
Section 160.	Miscellaneous and Technical Corrections . . .	18
o	Survey and Certification Requirements	18
o	Home Dialysis Demonstration Technical Corrections .	18
o	Technical Correction to Revisions of Coverage for Immunosuppressive Drug Therapy	18

SUBTITLE D -- PROVISIONS RELATING TO MEDICARE
SUPPLEMENTAL INSURANCE POLICIES

Section 171.	Standards for Medicare Supplemental Insurance Policies	19
o	Preventing Duplication	19
o	Loss Ratios and Refunds of Premiums	20
o	Treatment of HMOs	20
o	Open Enrollment	20
o	Health Insurance Counseling	20
o	Effective Date and Transition Provisions	21
o	Other Minor and Technical Amendments	21
Section 172.	6-Month Extension of Period for Issuance of Medicare SELECT Policies	21

TITLE II -- MEDICAID-RELATED PROVISIONS

SUBTITLE C -- SUPPLEMENTAL SECURITY INCOME

Section 221.	Definition of Disability for Children Under Age 18 Applied to All Individuals Under Age 18 . .	22
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SUBTITLE D -- AID TO FAMILIES WITH DEPENDENT CHILDREN

Section 231.	Simplification of Income and Eligibility Verification System	22
Section 232.	Measurement and Reporting of Welfare Receipt .	22

TITLE I -- MEDICARE

SUBTITLE A -- PROVISIONS RELATING TO PART A

Section 101. Provisions Relating to Adjustments to Standardized Amounts for Wages and Wage-Related Costs

Under prior law, the Medicare Geographic Classification Review Board (MGCRB) guidelines were based on a reclassification system using metropolitan statistical areas as the definition of labor market areas. This amendment allows the Secretary to change the guidelines for the MGCRB if the hospital wage index is changed so that metropolitan statistical areas are no longer the basis for the labor market areas. Effective upon enactment. The section also makes other minor technical changes.

Section 102. Essential Access Community Hospital (EACH) Amendments

Under prior law, grants were provided to facilities in seven States to design networks around the concept of a limited service hospital. These small facilities, Rural Primary Care Hospitals (RPCBs), are linked in referral networks with the larger referral EACH hospitals. Both of these facility types, once certified, become part of the operating program under Medicare. This amendment (beyond making minor technical corrections):

- Re-authorizes EACH/RPCH program appropriations through fiscal year (FY) 1997 at the current annual level of \$25 million;
- Changes the 72 hour limit on inpatient admissions to an average of 72 hours;
- Qualifies urban hospitals as EACHs, although these providers will not receive a change in Medicare payment as a result of this new designation;
- Authorizes a RPCH that had a swing bed agreement (at the time that it applies to be a RPCH) to retain all of its licensed beds for extended care services in addition to the 6-12 beds it is allowed under the RPCH program;
- Prohibits RPCHs from providing surgery or other services that require general anesthesia, unless the attending physician certifies that the risk of transfer to another facility outweighs the benefits;

- Changes the date for implementation of inpatient and outpatient rural primary care hospital prospective payment is from January 1, 1993 to January 1, 1996.

This section is effective upon enactment.

Section 103. Provisions Relating to Rural Health Transition Grant Program

This provision extends the Rural Health Transition Grant Program through FY 1997 and authorizes \$30 million annually. It also changes the reporting frequency from six months to once a year. Rural Primary Care Hospitals would be eligible to receive grants. Effective upon enactment.

Section 104. Psychology Services in Hospitals

This amendment allows clinical psychologists to supervise the care of Medicare patients in a hospital if they are authorized to do so under State law. Effective upon enactment.

Section 105. Medicare-Dependent, Small Rural Hospitals and Sole Community Hospitals

This provision makes minor technical amendments to OBRA-1993, effective upon enactment.

Section 106. Skilled Nursing Facilities

o Construction of Wage Index.

This amendment requires the Secretary to begin to collect SNF wage data within one year of date of enactment for the purposes of constructing a SNF wage index.

o Clarification of Repeal of Utilization Review Requirements.

OBRA-1987 amendments created confusion about whether or not a utilization review plan is required for skilled nursing facilities (SNFs) and other providers of extended care services. Section 1819 enumerates quality assurance and other requirements for SNFs, but does not explicitly require utilization review activities. However, other sections of the Act (sections 1866(d) and 1814(a)(5)) do make reference to SNFs and extended care services in the context of utilization review requirements. This amendment eliminates all references to SNFs and post-hospital extended care services in sections 1866(d) and 1814(a)(5), and thereby clarifies that utilization review plans and activities for SNFs and extended care services are permitted, but not required. The effective date is as if included in the enactment of OBRA-1987.

o **Conforming Amendments to Nursing Home Reform.**

Under prior law, the Secretary could prohibit approval of a nurse aide training program offered by a SNF if, within the previous two years, the SNF had been subject to an extended recertification survey. This section clarifies that such a prohibition is not authorized if the extended survey shows that the SNF is in compliance with the Medicare participation requirements of section 1819. This amendment also makes other technical and conforming amendments to correspond to Medicaid Nursing Home Reform.

This section also increases the minimum amount required for separate deposit of personal funds from \$50 to \$100.

This section also clarifies that a State shall not include, in a nurse aide registry, allegations of resident abuse or neglect or misappropriation of resident property unless such allegations are specifically documented by the State.

Section 107. Notification of Availability of Hospice Benefit

This provision requires hospitals to notify beneficiaries, as part of the discharge planning process, of the availability of hospice services. The effective date is the first day of the first month beginning more than one year after date of enactment.

Section 108. Clarifying Expertise of Individuals to Serve on the Prospective Payment Assessment Commission

This amendment changes the qualifying expertise for ProPAC commissioners to permit appointment of persons with other than hospital backgrounds. Effective upon enactment.

Section 109. Authority for Budget Neutral Adjustments for Changes in Payment Amounts for Transfer Cases

This amendment gives the Secretary authority to make budget neutral adjustments to the prospective payment system (PPS) standardized amounts when changes are made to transfer payment policy. Effective upon enactment.

Section 110. Clarification of DRG Payment Window Expansion; Miscellaneous and Technical Corrections

Under prior law, the DRG payment window of 3 days applied to all hospitals, PPS and otherwise. This amendment changes the payment window to one day for non-PPS hospitals. The provision also makes other technical corrections to Part A. Effective upon enactment.

SUBTITLE B -- PROVISIONS RELATING TO PART B

Part I -- Physicians' Services

Section 121. Development and Implementation of Resource-Based Methodology for Practice Expenses

This section requires the Secretary to develop a methodology for implementing a resource-based system for determining practice expense relative value units for all physicians' services. The Secretary must report to Congress on the methodology by June 30, 1996. The methodology must be implemented by January 1, 1998.

Section 122. Geographic Cost of Practice Index Refinements

This amendment requires the Secretary to consult with appropriate representatives of physicians in the periodic review of geographic cost of practice indices (GPCIs). This section also requires the use of the most recent data in establishing GPCIs. Finally, it requires a report to Congress, within one year from enactment, on the availability, limits, and costs of collecting GPCI data.

Section 123. Extra-Billing Limits

o Enforcement of Limits.

This provision: (1) clarifies rules applicable to non-participating physicians and suppliers regarding beneficiary liability and physician sanctions, and (2) requires timely refunds for non-participating physicians (effective upon enactment), and timely refunds for non-participating suppliers or other persons (effective January 1, 1995).

o Clarification of Mandatory Assignment Rules for Certain Practitioners.

This amendment clarifies that mandatory assignment applies to all services furnished by non-physician practitioners who bill Medicare on a fee-for-service basis, effective January 1, 1995.

o Information on Extra-Billing Limits.

Effective July 1, 1995, this section requires carriers to include, in the Explanation of Medicare Benefits (EOMBs), information regarding the applicable limiting charge (including information concerning the right to a refund) if the limiting charge was exceeded.

Also, effective for contracts as of January 1, 1995, this section requires carriers to: determine, prior to making payment, if the limiting charge was exceeded; notify the physician periodically of excess charges; and provide for prompt response to physician inquiries concerning the accuracy of limiting charges.

- o Report on Charges in Excess of Limiting Charge.

This amendment requires the Secretary's annual report to Congress on assignment, participation, and beneficiary out-of-pocket expenses to include information on limiting charge excesses, effective with reports beginning with 1995.

- o Miscellaneous and Technical Amendments.

This section also makes a conforming change allowing restitution to beneficiary from civil money penalties collected for violations of mandatory assignment for laboratory services, effective upon enactment.

Section 124. Relative Values for Pediatric Services

This amendment requires the development of relative values for the full range of pediatric services, including necessary refinements, by July 1, 1995. It also requires the Secretary to conduct a study and report to Congress by July 1, 1995 on whether there are significant variations in the resources used in providing pediatric and other services to different populations, and to recommend whether coding or payment changes are needed to appropriately reflect the resources involved in providing pediatric services.

Section 125. Administration of Claims Relating to Physicians' Services

- o Limitation on Carrier User Fees.

Effective upon enactment, the Secretary and carriers are prohibited from imposing user fees for five specified activities: filing claims; errors in filing claims or denied claims; appeals; obtaining a unique identifier; and responding to inquiries about physician services or providing information in response to medical review of services.

- o Clarification of Permissible Substitute Billing Arrangements.

Prior law allowed substitute billing arrangements (i.e., payment made to one physician for the services of a second physician) only for medical visits furnished on a reciprocal basis for no more than 60 days. This provision expands permissible substitute billing arrangements to include

arrangements involving per diem or other fee-for-time compensation. The provision also allows all physician services (rather than just visits) to be covered. The provision maintains the limitation that the substitute physician provide services for a period not exceeding 60 continuous days and requires that the second physician's unique identifier be reported on the first physician's claim. Effective with the first month beginning more than 60 days after enactment.

Section 126. Miscellaneous and Technical Corrections

o Overvalued Procedures.

This amendment corrects the list of overpriced procedures as designated in section 4101 of OBRA-1990. Effective as if included in OBRA-1990.

o Radiology Services.

This amendment corrects the radiology reductions (section 4102 of OBRA-1990) so as not to increase fees below the target. Effective as if included in OBRA-1990.

o Anesthesia Services.

This amendment corrects the anesthesia reductions (section 4103 of OBRA-1990) so as not to increase fees below the target. Effective as if included in OBRA-1990.

o Assistants at Surgery.

This section clarifies that the limiting charge in 1991 could not exceed the applicable percentage of the prevailing charge associated with the payment for an assistant-at-surgery. Effective as if included in OBRA-1990.

o Technical Components of Diagnostic Services.

This provision clarifies that the list of diagnostic services capped by section 4108 of OBRA-1990 would not also be reduced under other OBRA-1990 provisions. Effective as if included in OBRA-1990.

o Statewide Fee Schedules.

This provision mandates that Nebraska and Oklahoma be treated as statewide areas for purposes of the Medicare fee schedule (note that Nebraska and Oklahoma have already become statewide areas under the Medicare physician fee schedule), but eliminates the special OBRA-1990 conditions (section 4117) for such treatment. Effective as if included in OBRA-1990.

o Other Miscellaneous and Technical Amendments.

This amendment also makes other technical and conforming changes to OBRA-1990 relating to physician payment, effective as if included in OBRA-1990.

o Other Corrections.

This amendment eliminates the reporting requirement for the mandated study regarding use of time in medical visits, effective upon enactment. This amendment also repeals, effective beginning with FY 1994, the provision giving carriers bonuses equal to 1 percent of the carrier annual budget in order to increase participation of physicians and suppliers.

Part II -- Durable Medical Equipment

Section 131. Certification of Suppliers

o Requirements.

This amendment establishes the following requirements:

- Stipulates that, beginning on the date of enactment, no payment may be made to suppliers of medical equipment and supplies unless they obtain a supplier number and meet standards established by the Secretary. The section also requires the Secretary to establish, by January 1, 1996, additional standards related to: compliance with State and Federal licensure requirements, maintenance of a physical facility, and proof of product liability insurance. The above requirements do not apply to medical equipment and supplies furnished incident to a physician's service.
- Prohibits the issuance of more than one supplier number to a supplier unless more than one number is appropriate to identify subsidiary or regional entities under the supplier's ownership or control.
- Prohibits the Secretary from delegating (other than to a carrier) the responsibility of determining whether suppliers meet the supplier standards.
- Expands the category of suppliers to whom the prohibition on completing certificate of medical necessity (CMN) forms applies, to include suppliers of prosthetics, orthotics, and other medical supplies. Allows suppliers to complete the administrative portion of forms and requires suppliers to include the charge and fee schedule amount on the form.

- Requires the Secretary to annually review the coverage and utilization of durable medical equipment (DME) items, prosthetics, orthotics, and other medical supplies to determine whether certain items should be made subject to coverage and utilization criteria.

- o Use of Covered Items by Disabled Beneficiaries.

This provision requires the Secretary to study the impact of Medicare payments on the ability of disabled beneficiaries to obtain DME, including customized items. A report on the study is due to Congress one year after enactment.

- o Criteria for Treatment of Items as Prosthetic Devices or Orthotics and Prosthetics.

This provision requires the Secretary to report to Congress on prosthetic devices and orthotics that do not require custom fitting and recommend an appropriate payment methodology for these items. The report is due one year after enactment.

Section 132. Restrictions on Certain Marketing and Sales Activities

With limited exceptions, this section prohibits suppliers from contacting beneficiaries by telephone regarding the provision of an item of DME, prosthetics, and orthotics. No payment may be made to a supplier for an item furnished in violation of this provision. A supplier may be excluded from the program for a pattern of violations. Suppliers are required to make refunds to beneficiaries for any amounts collected on unassigned claims for items furnished in violation of the provision.

Section 133. Beneficiary Liability for Noncovered Services

- o Unassigned Claims.

Under prior law, physicians were required to make refunds to beneficiaries for unassigned claims for their services that are denied as medically unnecessary. This refund requirement for unassigned claims applied only to physician services.

This amendment expands the refund requirements to DME, prosthetics, orthotics, and medical supplies. It requires suppliers to make refunds to beneficiaries when these items are furnished on an unassigned basis if: payment is denied for lack of medical necessity; an item is furnished by a supplier who does not have a supplier number; or a prior authorization denial is made.

o Assigned Claims.

Under prior law, beneficiaries were not liable for assigned claims (including DME, prosthetics, orthotics, and medical supplies) denied as medically unnecessary. Beneficiaries were indemnified by the program for any amounts paid, and Medicare collected amounts owed from the provider or supplier.

This amendment expands the limitation of beneficiary liability for items of DME, prosthetics, orthotics, and medical supplies to certain situations other than medical necessity denials. Specifically, beneficiaries will not be liable when: an item is furnished by a supplier who does not have a supplier number; payment is denied because of violation of the telemarketing provisions; or a prior authorization denial is made. In these instances, suppliers are required to make refunds to beneficiaries for any amounts paid.

Section 134. Adjustments for Inherent Reasonableness

This amendment elaborates on the Secretary's authority to make adjustments to payments for an item of DME, prosthetics, and orthotics if the payment amount that would result from the application of ordinary DME payment rules would be inherently unreasonable (excessive or deficient). Specifically, new language is added that expressly refers to the issue of whether payment is inherently reasonable "on the basis of prices and costs applicable at the time the item is furnished." The section also requires that this inherent reasonableness determination be made for decubitus care equipment, transcutaneous electrical nerve stimulators (TENS), and any other item considered appropriate by the Secretary.

Section 135. Miscellaneous and Technical Corrections

o Updates to Payment Amounts.

This section makes a minor technical correction.

o Advance Determinations of Coverage.

Under prior law, carriers were required to make prior approval decisions for seat-lift mechanisms, TENS, motorized scooters, and other items determined by the Secretary to be frequently subject to unnecessary utilization.

This amendment eliminates the former prior authorization provision and gives the Secretary the authority to require prior authorization for: (1) items frequently subject to unnecessary utilization, either in a carrier's entire service area or a portion of that area; and (2) items furnished by suppliers with a pattern of over-utilization or a substantial

number of claims that are denied as medically unnecessary. The provision also requires prior authorization for customized items if requested by the beneficiary or supplier. The provision is expanded to include prosthetics and orthotics in addition to DME.

o Study of Variations in DME Supplier Costs.

This provision requires HCFA to study DME cost data to determine the proportion of costs that are "service" versus "product" costs, and the extent to which these proportions vary by type of equipment and by geographic region. It also requires HCFA to submit a report to Congress which analyzes the data, recommends a geographic cost index for supplier costs, and analyzes the impact of such an index on Medicare payments. The report is due on July 1, 1995.

o Other Miscellaneous and Technical Corrections.

The amendment also makes minor miscellaneous and technical corrections.

Part III -- Other Items and Services

Section 141. Ambulatory Surgical Center Services

o Payment Amounts for Services Furnished in Ambulatory Surgical Centers.

This amendment:

- Requires surveys of the actual audited costs incurred in ambulatory medical centers (ASCs), beginning January 1, 1995 and every 5 years thereafter, to determine payment amounts.
- Beginning with FY 1996, provides for automatic Consumer Price Index for Urban Areas (CPI-U) updates for ASC services if the Secretary has not otherwise updated the payment amounts for such services.
- Requires consultation with trade and professional groups in developing the list of ASC procedures.

o Adjustments to Payment Amounts for New Technology Intraocular Lenses.

This amendment:

- Requires the Secretary to develop a process for interested parties to request review of the appropriateness of

Medicare payment amounts for a class of new technology intraocular lenses (IOLs).

- Provides that the Secretary, in determining whether a payment adjustment should be made in response to a request for review under the above process, shall take into account whether the lens would result in: reduced risk of operative complications; accelerated postoperative recovery; reduced astigmatism; and other factors.
- Requires the Secretary to publish a notice in the Federal Register, at least annually, which lists the requests made for payment adjustments for new technology IOLs and provides for a 30-day comment period. The Secretary is also required to publish a subsequent notice of the determinations made on such payment adjustments requested.

o Other Technical Corrections.

This section makes other technical corrections.

Section 142. Study of Medicare Coverage of Patient Care Costs Associated with Clinical Trials of New Cancer Therapies

This provision requires the Secretary to study the effects of Medicare coverage of the patient care costs associated with clinical trials of new cancer therapies (where the protocol for the trial has been approved by the National Cancer Institute or meets similar scientific and ethical standards). The study must include an estimate of the cost of coverage, an assessment of whether clinical trials provide the best available treatment, an assessment of whether Medicare coverage would lead to progress in developing new anticancer therapies, and an evaluation of whether there should be criteria for admission of Medicare beneficiaries. A study report is due to Congress within two years of enactment.

Section 143. Study of Annual Cap on Amount of Medicare Payment for Outpatient Physical Therapy and Occupational Therapy Services

This amendment requires the Secretary to study the appropriateness of continuing an annual limitation on payments for outpatient services of independently practicing physical and occupational therapists. A report must be submitted to Congress by January 1, 1996, and include a recommendation for making any changes in the annual limitation, as appropriate.

Section 144. Payment of Part B Premium Late Enrollment Penalties by States

This provision allows States to pay the Secretary, on a quarterly or other periodic basis, a lump sum for the total amount of the part B enrollment surcharges for a group of Medicare beneficiaries.

Section 145. Application of Mammography Certification Requirements

This provision conforms requirements for Medicare coverage of mammography services to the Mammography Quality Standards Act (MQSA) of 1992. Screening mammography services and diagnostic mammography services will be covered only if conducted by a facility that has a certificate of compliance, or provisional certificate, issued by the Public Health Service.

Section 146. Coverage of Services of Speech-Language Pathologists and Audiologists

This section defines speech-language pathology services and audiology services and makes conforming amendments.

Section 147. Miscellaneous and Technical Amendments

- o Immediate Enrollment in Part B by Individuals Covered by an Employment-Based Plan.

Under prior law, the special enrollment period (SEP) allowed individuals with employer group health plan (EGHP) coverage to enroll in Part B beginning with the first month that the individual is no longer enrolled in the EGHP and ending seven months later. This amendment revises the SEP for individuals with EGHP coverage to allow them to enroll in Part B at any time that they are still enrolled in the EGHP and up until 8 months after their EGHP coverage ends.

- o Other Technical Amendments.

The section also makes other technical corrections.

SUBTITLE C -- PROVISIONS RELATING TO PARTS A AND B

Section 151. Medicare Secondary Payer Reforms

- o Improving Identification of Medicare Secondary Payer Situations.

To improve the Secretary's identification of Medicare secondary payer (MSP) situations, this amendment:

- Mandates that HCFA provide beneficiaries an initial enrollment questionnaire on which they identify whether Medicare would be the primary or secondary payer. Effective date is 60 days after enactment.
- Prohibits the denial of Medicare payment solely on the grounds that the beneficiary does not return the questionnaire. Effective upon enactment.
- Mandates denial of Part B claims if the provider does not complete the Medicare secondary payer (MSP) questions on the claim form. Civil money penalties may be levied on entities that knowingly, willfully and repeatedly fail to, or inaccurately complete, the MSP questions on the claim form. Effective date is 120 days after enactment.

- o Improvements in Recovery of Payments from Primary Payers.

This provision requires contractors (fiscal intermediaries and carriers) to submit to the Secretary annual reports describing the steps taken to recover mistaken Medicare primary payments. It further mandates that contractors be subject to standards and criteria relating to success in payment recovery in their performance evaluations. This provision is effective for contract years beginning with 1995.

- o Deadline for Reimbursement by Primary Plans.

This amendment codifies the current policy on payment of interest if recoveries are not received within 60 days of notice. Effective upon enactment.

- o Miscellaneous and Technical Corrections.

This section also makes technical corrections to OBRA-1993, OBRA-1990, and OBRA-1989.

Section 152. Physician Ownership and Referral

o Reporting Requirements.

This amendment extends the reporting requirement, which currently applies to physician ownership arrangements, to physician investment and compensation arrangements. Effective upon enactment. The provision also makes other minor technical amendments.

o Designated Health Services List.

This provision deletes reference to "other diagnostic services" from the list of services subject to the referral ban and clarifies that radiology services include magnetic resonance imaging, computerized axial tomography scans, and ultrasound services. The effective date is for referrals made on or after January 1, 1995.

This provision also clarifies that the referral ban applies to supplies used in conjunction with radiation therapy services, durable medical equipment, and prosthetics, orthotics and prosthetic devices. The effective date is for referrals made on or after January 1, 1995.

o Revision of Effective Date Exception.

This amendment revises the exceptions built into the OBRA-1993 effective date provisions.

Referrals made for clinical laboratory services before January 1, 1995 are not subject to the following OBRA-1993 provisions:

- Expansion of the definition of financial relationship to include ownership or investment interest in an entity that holds an ownership or investment interest in an entity that provides designated health services;
- Requirement for group practices receiving the in-office ancillary services exception that services be billed under a group practice's billing number, and that members of the group personally conduct at least 75 percent of the physician-patient encounters;
- Rural services exception requirement that substantially all services provided by a rural provider are to residents living in the rural area; and
- Prohibition on group practices receiving an in-office exception from having direct or indirect compensation arrangements based on volume or value of referrals, or

overall profits and productivity bonuses that are based on volume or value of referrals.

The following provisions are a combination of pre-OBRA-1993 exceptions and OBRA-1993 revisions:

- With regard to ownership or investment in publicly traded securities, corporations that meet the pre-OBRA-1993 total assets requirement (\$100,000,000 in most recent fiscal year) are not subject to the corresponding OBRA-1993 provisions (\$75,000,000 in the most recent year or this amount, on average, over the last three fiscal years).
- OBRA-1993 exceptions for compensation under personal service arrangements shall apply except to arrangements that satisfy pre-OBRA-1993 requirements either for employment and service arrangements with hospitals or for service arrangements with non-hospital entities.

The following pre-OBRA-1993 provisions remain in effect until January 1, 1995 with regard to the provision of clinical laboratory services:

- Exception for ownership and compensation arrangements with hospitals as long as the relationship does not relate to the provision of clinical laboratory services.
- Exception for ownership or investment of publicly-traded securities that are available on terms generally available to the public and are in a corporation listed on the New York Stock Exchange (NYSE), American Stock Exchange (ASE), or traded under an automated inter-dealer system operated by the National Association of Securities Dealers (NASD).
- Exception for rental of office space under the prohibited compensation arrangements.

Section 153. Definition of FMGEMS Examination for Payment of Direct Graduate Medical Education

This amendment allows the Secretary to recognize the successor exam to the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS). Successful completion of this exam is required for foreign medical graduates to be included in the full-time equivalent (FTE) count used for Medicare payment purposes.

Section 154. Qualified Medicare Beneficiary Outreach

This provision requires the Secretary to obtain information from newly eligible Medicare beneficiaries that may be used to determine their eligibility as qualified Medicare beneficiaries

(QMBs), and to report this information to their state of residence.

Section 155. Hospital Agreements with Organ Procurement Organizations

This provision requires a hospital or rural primary care hospital to have an agreement (described in section 371(b)(3)(A) of the Public Health Service Act) only with an Organ Procurement Organization (OPO) designated for the service area in which the hospital is located. Any hospital that desires to have an agreement with a non-designated (out-of-area) OPO must submit an application for a waiver to the Secretary. Furthermore, any hospital that desires to continue an existing agreement with an out-of-area OPO must submit an application for a waiver to the Secretary by January 1, 1996. The existing agreement remains in effect pending the Secretary's determination.

In granting a waiver for an out-of-area agreement, the Secretary must determine that such a waiver: (a) would be expected to increase organ donation, and (b) will assure equitable treatment of patients referred for transplants within the service area served by the designated OPO and within the service area served by the out-of-area OPO. In making a waiver determination, the Secretary may consider, among other factors: (a) cost effectiveness, (b) improvements in quality, (c) whether there has been any change in a hospital's designated OPO service area due to a redefinition of metropolitan statistical areas (MSAs), and (d) the length and continuity of a hospital's relationship with the out-of-area OPO. The Secretary must publish a notice of any waiver application and offer interested parties an opportunity to comment in writing within 60 days.

The provision also mandates the Office of Technology Assessment (OTA) to study and make recommendations on the impact of the new requirements on the fairness and efficacy of organ procurement and distribution.

Section 156. Peer Review Organizations

- o Repeal of PRO Precertification Requirement for Certain Surgical Procedures.

Section 1164 of the Act, which requires 100 percent peer review for certain surgical procedures, is repealed. Other sections of the Act referencing section 1164 are revised to conform.

- o PRO Notification of State Licensing and Disciplinary Boards.

Prior law has been unclear about those circumstances where a Peer Review Organization (PRO) must notify a State licensing

or disciplinary board of findings related to a physician's performance. Section 1154(a)(9)(B) could be interpreted to require State notification whenever physician services fail to meet the broad medical necessity, quality, and appropriate setting standards. Yet, this would be operationally infeasible.

This amendment clarifies the ambiguity by requiring a PRO to notify a State board, after reasonable notice to and opportunity for discussion with the physician, in those instances where the PRO has (1) found that the physician has furnished services in violation of the medical necessity, quality and appropriate setting standards under section 1156(a), and (2) determined that the physician should enter into a corrective action plan under section 1156(b)(1). The amendment is effective as of enactment.

Section 157. Health Maintenance Organizations

0 Revisions in the Payment Methodology for Risk Contracts.

This provision requires the Secretary to submit a proposal to Congress by October 1, 1995 for the revision of the payment methodology for risk contractors. Such revised methodology would be used for payment purposes beginning in 1997. In making the revisions, the Secretary is to consider the need for adjustors for health status and demographic characteristics, and for alternative geographic classifications. Before January 1, 1996, the General Accounting Office (GAO) is to report to Congress on the appropriateness of the proposed revisions.

0 Miscellaneous and Technical Corrections.

The section also contains miscellaneous and technical corrections.

Section 158. Home Health Agencies

0 Use of Most Current Data in Determining Wage Index.

Under prior law, it was unclear what year's hospital wage index should be used to calculate the labor component of the home health agency (HHA) payment upon the completion of the cost limit freeze of OBRA-1993's section 13564(a). This provision clarifies that upon the completion of the OBRA-1993 cost limit freeze, HHA cost limits will be established by using the most recent available hospital wage index survey data. The provision applies with respect to cost reporting periods beginning on or after July 1, 1996.

o Clarification of Extension of Waiver of Liability.

OBRA-1990 extended, until December 1, 1995, the expiring limitation on liability provision for home health service coverage denials pursuant to section 1879. OBRA-1990 neglected to extend the limitation on liability protections for home health services denied under section 1862(a)(1)(A), which relates to services not medically reasonable or necessary. This provision corrects this omission, extending the waiver of liability for coverage denials under section 1862(a)(1)(A) until December 1, 1995. The provision is effective as if included in OBRA-1990.

Section 159. Permanent Extension of Authority to Contract with Fiscal Intermediaries and Carriers on Other Than a Cost Basis

This amendment retroactively restores, and makes permanent, the authority to enter into contracts and agreements without regard to cost reimbursement when mutually agreed to by the Secretary and the fiscal intermediaries and carriers.

Section 160. Miscellaneous and Technical Corrections

o Survey and Certification Requirements.

This amendment:

- Clarifies that the OBRA-1990 provision that established a prohibition on user fees under title XVIII does not apply to user fees relating to the Clinical Laboratory Improvement Amendments (CLIA) of 1988.
- Removes the requirement that the Secretary contract with State agencies to ensure compliance of non-Medicare clinical laboratories with CLIA. Replaces this requirement with discretionary authority allowing the Secretary to contract with State or local agencies for this purpose.

o Home Dialysis Demonstration Technical Corrections.

This provision makes a number of technical changes to the requirements for the demonstration on staff-assisted home dialysis.

o Technical Correction to Revisions of Coverage for Immunosuppressive Drug Therapy.

OBRA-1993 expanded coverage of immunosuppressive drugs by phasing-in an extension of the number of months of coverage between 1995 (18 months of coverage) and 1997 (36 months). The provision, however, expanded coverage in such a manner.

that beneficiaries would experience lapses in coverage. This amendment eliminates these gaps in coverage by allowing the Secretary to administer the provision so that consecutive months of coverage are furnished, as long as the total number of months of coverage allowed by OBRA-1993 are the same.

**SUBTITLE D -- PROVISIONS RELATING TO MEDICARE
SUPPLEMENTAL INSURANCE POLICIES**

Section 171. Standards for Medicare Supplemental Insurance Policies

o Preventing Duplication.

This provision clarifies and narrows the existing anti-duplication provisions. Under the revised statute, it is illegal to sell or issue the following health insurance policies to Medicare beneficiaries:

- a Medigap policy when the beneficiary already has a Medigap policy, unless the purchaser states in writing an intent to terminate the existing policy;
- a policy (other than Medigap or employer coverage) that duplicates private health benefits to which the beneficiary is already entitled, unless the policy pays benefits directly to the beneficiary without regard for other insurance coverage; and
- a policy (other than employer coverage) that duplicates Medicare or Medicaid benefits to which a beneficiary is already entitled. Exceptions under this section for Medigap policies are: (a) if a State Medicaid program pays the premiums for the policy, (b) for qualified Medicare beneficiaries (QMBs), if the policy includes prescription drug coverage, or (c) if payment of Part B premiums is the only medical assistance the individual receives from the Medicaid program. An exception is also made for other health insurance policies (e.g., dread disease policies) where the benefits are paid without regard to duplication in coverage, where applicable, and where a statement disclosing the duplication is included in the application.

Within 90 days of the enactment of this section, the National Association of Insurance Commissioners (NAIC) must, after consultation with consumer and insurance industry representatives, develop statements describing the extent of duplication for each of the types of health insurance policies and submit them to the Secretary for approval. The Secretary must approve or disapprove the statements within 30 days of

TITLE II -- MEDICAID-RELATED PROVISIONS

SUBTITLE C -- SUPPLEMENTAL SECURITY INCOME

Section 221. Definition of Disability for Children Under Age 18 Applied to All Individuals Under Age 18

This provision amends, effective upon enactment, the Supplemental Security Income program under title XVI of the Act to change the references to "a child" under age 18 who is disabled to "an individual" under age 18 who is disabled. This has the effect of deleting the requirement that the individual (to whom the special disability rules are being applied) be unmarried.

SUBTITLE D -- AID TO FAMILIES WITH DEPENDENT CHILDREN

Section 231. Simplification of Income and Eligibility Verification System

This provision amends section 1137 of the Social Security Act to conform the requirements for a written declaration of citizenship or immigration status, as a condition of eligibility for Aid to Families with Dependent Children (AFDC), Medicaid, or unemployment compensation, to those adopted in 1990 with respect to benefits under the Food Stamp program. Thus, effective upon enactment, the law will allow one member to submit and sign the declaration for all family members, and permit such a declaration to be filed with respect to a newborn in the family no later than the date of the family's next redetermination of eligibility.

Section 232. Measurement and Reporting of Welfare Receipt

This amendment requires the Secretary to develop indicators of welfare dependency and predictors of welfare receipt, and to report these findings to Congress no later than two years after enactment and annually thereafter. It also establishes an Advisory Board on Welfare Indicators to advise the Secretary on the content of reports to Congress.